[redacted]

Endo[redacted]

The Mount Sinai Medical Center
GASTROINTENSTINAL ENDOSCOPY UNIT
ENDOSCOPY REPORT

[redacted]

DATE: 01/16/2010
ENDOSCOPIST: NONE /Palmon,Ron

Procedure: Colonoscopy
Type of Prep: null
Biopsy: No
Cytology Taken: No
Report Status: Final
Quality of Prep: null
Photo Taken: No
Medications Administered:
Referral Reasons: Unexplained abdominal pain. Rule out colitis

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Procedure: Colonoscopy
Indication: Abdominal pain
Pre Procedure Diagnosis: Same As Indication
Post Procedure Diagnosis: Same As Indication
Site: Other
Depth of Insertion: Distal transverse colon
Findings: Endoscope passed to likely level of proximal transverse colon at which point solid stool encountered. The colonic mucosa was normal without any evidence of colitis or diverticulitis. There was one solitary area of [redacted]verticulum noted in the sigmoid. Rectum normal.

Pathology: None
Complications: No
Complication Type: None
Comments: Case discussed with Surgical Attending Dr. Nguyen. Plan for observation for 24 hrs. If still having pain then, consider repeat CT scan +/- diagnostic laparoscopy

[redacted] NONE(NONE)

Date: 01/16/2010

[redacted]

[redacted]

MOUNT SINAI ED
PRIMARY

[redacted]

Patient Data

Complaint: Abdominal Pain
Triage Time: Fri Jan 15, 2010 21:06
Urgency: ESI Level 3
Bed: ED NORTH 05A
Initial Vital Signs: 1/15/2010 20:58
BP:195/112 (Sitting)
P:63 (Brachial)
O2 sat:99% on Room Air

ED Attending: [redacted]
Primary RN: [redacted]

R:20
T:37.2 (Tymanic)
Pain:8

TRIAGE (Fri Jan 15, 2010 21:06 NAMC)

COMPLAINT: Abdominal Pain. (Fri Jan 15, 2010 21:06 NAMC)
PROVIDERS: TRIAGE NURSE: [redacted] (Fri Jan 15, 2010 21:06 NAMC)
ADMISSION: URGENCY: ESI Level 3, ADMISSION SOURCE: Home, TRANSPORT: Ambulatory, BED: AERNORTH. (Fri Jan 15, 2010 21:06 NAMC)
PATIENT: NAME: [redacted], AGE: 30, GENDER: male, DOB: [redacted], TIME OF GREET: Fri Jan 15, 2010 20:58, LANGUAGE: English, Isolation Precaution: .None Needed, abuse/assault: Deferred, Emerg. Surveillance: deferred, MEDICAL RECORD NUMBER: [redacted] ACCOUNT NUMBER: [redacted] (Fri Jan 15, 2010 21:06 NAMC)
ASSESSMENT: Pain level 8, using numeric pain scoring., pt. bib ems from white plains hospital due to abdominal x 3 days. vomited x 2. (Fri Jan 15, 2010 21:06 NAMC)
MENTAL STATUS: Orientation: Alert, **Oriented**, Behavior: Cooperative. (Fri Jan 15, 2010 21:06 NAMC)
ABDOMEN: **Nausea present, Vomiting present.** (Fri Jan 15, 2010 21:06 NAMC)
TREATMENT IN TRIAGE (Fri Jan 15, 2010 21:06 NAMC)
VITAL SIGNS: BP 195/112, (Sitting), Pulse 63, (Brachial), Resp 20, Temp 37.2, (Tympanic), Pain 8, O2 Sat 99%, on Room Air, Time 1/15/2010 20:58. (20:58 NAMC)

CALL IN (21:21 XWT)

NOTES: **ADULT PATIENT BEING CALLED IN BY DR SHAPIRO OF SURGERY--C/O ABDOMINAL PAIN--NOTIFY SURGERY PGR 3670 UPON PATIENT ARRIVAL.**
CALL IN: Call In: Fri Jan 15, 2010 21:21.

GREET (20:58)

GREET: Greet: Fri Jan 15, 2010 20:58.

CURRENT MEDICATIONS (21:06 NAMC)

Patient not taking any medications

DIAGNOSIS (22:26 AJB)

FINAL: PRIMARY: **Abdominal pain.**

PAST MEDICAL HISTORY

NOTES: Nursing records reviewed, Agree with nursing records, Old chart reviewed, Unable to obtain complete past history due to patient's condition. (22:24 AJB)
MEDICAL HISTORY: No past medical history (Fri Jan 15, 2010 21:06 NAMC)
PSYCHIATRIC HISTORY: No previous psychiatric history. (22:24 AJB)
SURGICAL HISTORY: Patient's previous surgical history is not relevant to the case. (22:24 AJB)
SOCIAL HISTORY: Denies alcohol abuse, Denies tobacco abuse, Denies drug abuse, Lives with others. (22:24 AJB)
FAMILY HISTORY: Family history is not contributory to this case. (22:24 AJB)

[redacted]

MOUNT SINAI ED
PRIMARY

[redacted]

HPI ABDOMINAL PAIN (22:24 AJB)
CHIEF COMPLAINT: Patient presents for the evaluation of **abdominal pain, vomiting**.
HISTORIAN: History obtained from patient.
TIME COURSE MALE: **Onset of symptoms reported as gradual**, Onset was **days prior to arrival** , **Patient currently has symptoms.**
LOCATION MALE: **Pain in lower abdomen**, Radiation is not present. .
SEVERITY: Maximum severity is **moderate**, Currently **symptoms are mild**.
ASSOCIATED WITH: **Associated with abdominal pain**, No recent antibiotic use, No bright red blood per rectum, No associated chills, No associated constipation, No associated diarrhea, No associated fever, No associated flank pain, No groin pain, No hematemesis, Not associated with hematuria, No associated loss of appetite, No melena, **Associated with nausea**, No associated night sweats, No testicular pain, No associated trauma, No recent travel, **Associated with inability to tolerate P.O. fluids**, No associated UTI Symptoms, **Associated with vomiting**.
RISK FACTORS MALE: AAA risk factors N/A for this patient, Torsion testicle risk factors N/A for this patient.
EXACERBATED BY: Patient's condition exacerbated by nothing.
RELIEVED BY: Patient's condition relieved by **nothing**.

ROS (22:25 AJB)
CONSTITUTIONAL: No fever, No chills, No night sweats.
EYES: No eye pain.
ENT: No sore throat.
CARDIOVASCULAR: No chest pain.
RESPIRATORY: No SOB.
GI: **Historian reports abdominal pain, Historian reports nausea, Historian reports vomiting**, No diarrhea, No hematemesis, No melena, No constipation.
GENITOURINARY MALE: No dysuria.
MUSCULOSKELETAL: No back pain.
SKIN: No cellulitis, No decubiti.
NEUROLOGIC: No dizziness.
ENDOCRINE: Negative endocrine review of systems.
HEMO/LYMPHATIC: Negative hemo/lymphatic review of systems.
ALLERGIC/IMMUNOLOGIC: Negative Allergic review of systems.
PSYCHIATRIC: Negative psychiatric review of systems.
ALL SYSTEMS NEGATIVE: All systems were reviewed and are negative except as described above.

PHYSICAL EXAM (22:25 AJB)
CONSTITUTIONAL: Patient is afebrile, Vital signs reviewed, Patient has normal pulse, Patient has normal blood pressure, Patient has normal respiratory rate, Well appearing, Patient appears comfortable, Alert and oriented X 3.
HEAD: Atraumatic, Normocephalic.
EYES: Eyes are normal to inspection, No discharge from eyes, Sclera are normal, Conjunctiva are normal.
ENT: Ears normal to inspection, Nose examination normal, Mouth normal to inspection.
NECK: Normal ROM, No jugular venous distention, No meningeal signs, Cervical spine nontender.
RESPIRATORY CHEST: Chest is nontender, Breath sounds normal, No respiratory distress.
CARDIOVASCULAR: RRR, Heart sounds normal.
ABDOMEN: No pulsatile masses, No other masses, Bowel sounds normal, No distension, No peritoneal signs, No hernias, McBurney's point nontender, No Murphy's sign, Liver and spleen normal, **Tenderness, is**

diffuse, which is mild in intensity.
BACK: There is no CVA Tenderness, There is no tenderness to palpation, Normal inspection.
UPPER EXTREMITY: Inspection normal, No cyanosis, No clubbing, No edema, Normal range of motion, Normal pulses.
LOWER EXTREMITY: Inspection normal.
NEURO: GCS is 15, No focal motor deficits, Speech normal, Memory normal.
SKIN: Skin is warm, Skin is dry, Skin is normal color.
PSYCHIATRIC: Oriented X 3, Normal affect, Normal insight, Normal concentration.

ATTENDING

ADDITIONAL NOTES: 30M
INPT WHITE PLAINS HOSP
TRANSFEREED WITH EMS TO MSH ED
SURG AWARE OF TRANSFER, NGUYEN
ED PERSONNEL NOT AWARE
HARD COPY MED RECORDS REVIEWED
LAB RESULTS AND MED ORDERS
SINGLE CT READ WITH FINDINGS CW SBO
DW SURGERY
THEY WILL SEE PT IN ED
IV ACCESS
LABS FOR PRE OP AND ABD EVAL
NPO
IVF. (21:33 AJB)
?? DX AT WHITE PLAINS
REF TO SINAI
PROBS WITH HOSP TO JHOSP TRANSFER....PT TO ED
SEEN BY SURG IN ED....NO DW ED ATTENDING
WILL HYDRATE AND ADMIN PAIN MEDS. (21:55 AJB)

VITAL SIGNS

VITAL SIGNS: BP: 195/112 (Sitting), Pulse: 63 (Brachial), Resp: 20, Temp: 37.2 (Tympanic), Pain: 8, O2 sat: 99% on Room Air, Time: 1/15/2010 20:58. (20:58 NAMC)
BP: 178/110 (Lying), Pulse: 71, Resp: 18, Temp: 37.4 (Tympanic), Pain: 2, O2 sat: 95% on Room Air, Time: 1/15/2010 22:28. (22:28 TKS)
BP: 164/107, Pulse: 104, Resp: 20, Temp: 37, Pain: 2, O2 sat: 98% on Room Air, Time: 1/15/2010 23:58. (23:58 TKAS)

EKG INTERPRETATION (22:22 AJB)

MONITOR STRIP: Interpreted by ED Physician.
12 LEAD EKG INTERPRETATION: 12 lead EKG interpreted by ED Physician, No previous EKG available, Initial EKG, 12 Lead EKG Interpretation shows rhythm is Normal Sinus, Rate is normal, Conduction is normal, Normal ST/T waves, T-Waves: inversion, Areas Affected: inferior leads, Axis: normal, non-specific EKG.

O2SAT INTERPRETATION (21:26 AJB)

O2SAT: O2 saturation reading 99%, O2 AMT: R.A., O2 Sat normal, Patient is being observed.

KNOWN ALLERGIES

Aspirin

[redacted]

MOUNT SINAI ED
PRIMARY

[redacted]

MEDICATION ADMINISTRATION SUMMARY

Drug Name	Dose Ordered	Route	Status	Time
Sodium Chloride 0.9%, Intravenous	1L WIDE AND 100 mL/hr	IV infusion	Given	22:23 1/15/2010
Dilaudid	2 milligram(s)	IVPB	Given	22:10 1/15/2010

Detailed record available in Medication Service section.

ORDERS

GEM 3000 by .Bruns, MD #78703, John for .Bruns, MD #78703, John on Fri Jan 15, 2010 21:32 Status: Active
ER VENOUS PANEL by .Bruns, MD #78703, John for .Bruns, MD #78703, John on Fri Jan 15, 2010 21:32 Status: Done by System Fri Jan 15, 2010 23:09
NPO by .Bruns, MD #78703, John for .Bruns, MD #78703, John on Fri Jan 15, 2010 21:32 Status: Done by Barnett, RN, Brigitte Fri Jan 15, 2010 22:07
CBC, PLT & DIFF by .Bruns, MD #78703, John for .Bruns, MD #78703, John on Fri Jan 15, 2010 21:32 Status: Done by System Fri Jan 15, 2010 23:15
PTT by .Bruns, MD #78703, John for .Bruns, MD #78703, John on Fri Jan 15, 2010 21:32 Status: Done by System Fri Jan 15, 2010 23:40
PT by .Bruns, MD #78703, John for .Bruns, MD #78703, John on Fri Jan 15, 2010 21:32 Status: Done by System Fri Jan 15, 2010 23:39
POC Urinalysis by .Bruns, MD #78703, John for .Bruns, MD #78703, John on Fri Jan 15, 2010 21:32 Status: Done by Barnett, RN, Brigitte Fri Jan 15, 2010 22:24
EKG by .Bruns, MD #78703, John for .Bruns, MD #78703, John on Fri Jan 15, 2010 21:32 Status: Active
ABDOMINAL PAIN PANEL by .Bruns, MD #78703, John for .Bruns, MD #78703, John on Fri Jan 15, 2010 21:32 Status: Done by System Fri Jan 15, 2010 23:56
Type and Screen by .Bruns, MD #78703, John for .Bruns, MD #78703, John on Fri Jan 15, 2010 21:32 Status: Done by System Sat Jan 16, 2010 01:13

ASSESSMENT: ABDOMEN WITH PROCEDURES (Sat Jan 16, 2010 00:58 NBLB)

CONSTITUTIONAL: History obtained from patient, Patient is cooperative, Patient is alert and oriented x 3, Patient's skin is warm and dry, Patient's mucous membranes are moist and pink, Patient arrives to treatment area via EMS, Patient with steady gait, Patient appears in pain distress.
ABDOMEN: Non-distended, Positive bowel sounds in 4 quads, Patient denies nausea, Patient denies vomiting, Patient denies diarrhea, Patient denies constipation.
GENITOURINARY MALE: No complaint of pain, No discharge, No urinary complaints.
IV: Patient's identity verified by, patient stating name, patient stating birth date, Indications for procedure: fluid replacement, Indications for procedure: medication administration, IV established, 20 gauge catheter inserted, into right antecubital, #1 site, in 1 attempt, Saline lock established, flushed with normal saline, amount 10, ml, Labs drawn at time of placement, Specimen labeled in the presence of the patient and sent to lab, After procedure, no swelling noted at site, After procedure, no drainage noted at site, After procedure, no redness, IV line connections checked and properly labeled.
NOTES: **pt bib ems from white plains hospital. pt was at other hospital this week with abd pain. pt was fully worked up, had multiple ct scans, and was observed for a few days and was given no signifcant diagnosis (as per pt.). it was recommended that he come to sinai to be evaluated by an admitting md. pt alert, oriented and ambultory. no previous hx of htn. .**

NURSING PROCEDURE: ADMISSION (Sat Jan 16, 2010 01:14 NBLB)

TIME: Report called at 1:14, Patient admitted to room 9c – 223a, Patient acuity level was urgent, Patient

admitted to, med–surg unit, Report called/faxed to christian, rn, Provided opportunity to answer questions, Patient transported via, cart, Accompanied by, transport, Belongings are, with patient.

NURSING PROCEDURE: BEDSIDE TESTING (22:09 TKS)

CLINITEK 50(URINE DIPSTICK): Color is Yellow, pH is 7.0, Glucose negative, Protein positive, trace, Bilirubin positive, Large, Urobilinogen is 1.0, Ketone positive, >, Nitrate Negative, Specific Gravity 1.015, Leukocytes negative, Occult Blood negative.

NURSING PROCEDURE: EKG CHART (22:18 TKS)

TIME: Patient's identity verified by, patient stating name, patient stating birth date, hospital ID bracelet, EKG was performed at 2210, 12 lead EKG Performed–left chest.

PRESCRIPTION

No recorded prescriptions

DISPOSITION (22:27 AJB)

PATIENT: Disposition Transport: Ambulatory, Condition: 'Stable.

COMMUNICATION (21:25 XWT)

NOTES: **DR BRUNS REQUESTING SURGERY.**
SURGERY PAGED AND PATCHED TO DR BURNS.

MEDICATION SERVICE

Dilaudid: Order: Dilaudid (Hydromorphone Hydrochloride) : 4 Mg/Ml Solution – **Dose:** 2 milligram(s) : IVPB
Schedule: NOW
Ordered by: John .Bruns, MD #78703
Entered by: John .Bruns, MD #78703 Fri Jan 15, 2010 21:57
Documented as given by: Brigitte Barnett, RN Fri Jan 15, 2010 22:10
Patient, Medication, Dose, Route and Time verified prior to administration.
Time given: 2210, IVP, Initial medication, Slowly, Catheter placement confirmed via flush prior to administration, IV site without signs or symptoms of infiltration during medication administration, No swelling during administration, No drainage during administration, IV flushed after administration, Correct patient, time, route, dose and medication confirmed prior to administration, Patient advised of actions and side–effects prior to administration, Allergies confirmed and medications reviewed prior to administration.

Sodium Chloride 0.9%, Intravenous: Order: Sodium Chloride 0.9%, Intravenous (Sodium Chloride) : Sodium Chloride 0.9% Solution – **Dose:** 1L WIDE AND 100 mL/hr : IV infusion
Schedule: NOW
Ordered by: John .Bruns, MD #78703
Entered by: John .Bruns, MD #78703 Fri Jan 15, 2010 21:58
Documented as given by: Brigitte Barnett, RN Fri Jan 15, 2010 22:23
Patient, Medication, Dose, Route and Time verified prior to administration.
Catheter placement confirmed via flush prior to administration, IV site without signs or symptoms of infiltration during medication administration, No swelling during administration, No drainage during administration, IV flushed after administration, Correct patient, time, route, dose and medication confirmed prior to administration, Patient advised of actions and side–effects prior to administration, Allergies confirmed and medications reviewed prior to administration.

IMAGING

[redacted]

MOUNT SINAI ED
PRIMARY

[redacted]

FACE SHEET: Image captured from scanner. (22:28 RWE)
MEDICARE DISCHARGE APPEAL: Image captured from scanner. (22:31 RWE)
SIGNED AUTH AND AGREEMENTS FORM: Image captured from scanner. (22:31 RWE)
NOPP: Image captured from scanner. (22:31 RWE)
PROXY QUESTIONAIRE: Image captured from scanner. (22:31 RWE)
HIE CONSENT: Image captured from scanner. (22:32 RWE)
EKG: Image captured from scanner. (22:58 REB)

ATTESTATION BY ATTENDING (21:35 AJB)

NOTES: I have personally seen and examined this patient I have fully participated in the care of this patient I have reviewed all pertinent clinical information. I agree with the management and disposition of this patient, Nursing records reviewed, Agree with nursing records, I was physically present, saw, evaluated and participated in the management of the patient, confirming the patient history, ROS,PMH/FH/SH and PE as documented by, Unless otherwise indicated, all procedures were done or directly supervised by me, the teaching physician.

Key:

[redacted]

[redacted]

MOUNT SINAI ED
NURSING SUMMARY

[redacted]

TRIAGE (Fri Jan 15, 2010 21:06 NAMC)
COMPLAINT: Abdominal Pain. (Fri Jan 15, 2010 21:06 NAMC)
PROVIDERS: TRIAGE NURSE: [redacted]
(Fri Jan 15, 2010 21:06 NAMC)
ADMISSION: URGENCY: ESI Level 3, ADMISSION SOURCE: Home, TRANSPORT: Ambulatory, BED: AERNORTH.
(Fri Jan 15, 2010 21:06 NAMC)
PATIENT: NAME: [redacted] AGE: [redacted] GENDER: male, DOB: [redacted] 1979, TIME OF GREET: Fri Jan 15, 2010 20:58, LANGUAGE: English, Isolation Precaution: .None Needed, abuse/assault: Deferred, Emerg. Surveillance: deferred, MEDICAL RECORD NUMBER: [redacted] ACCOUNT NUMBER: [redacted]
(Fri Jan 15, 2010 21:06 NAMC)
ASSESSMENT: Pain level 8, using numeric pain scoring., pt. bib ems from white plains hospital due to abdominal x 3 days. vomited x 2. (Fri Jan 15, 2010 21:06 NAMC)
MENTAL STATUS: Orientation: Alert, **Oriented**, Behavior: Cooperative.
(Fri Jan 15, 2010 21:06 NAMC)
ABDOMEN: **Nausea present, Vomiting present.** (Fri Jan 15, 2010 21:06 NAMC)
TREATMENT IN TRIAGE (Fri Jan 15, 2010 21:06 NAMC)
VITAL SIGNS: BP 195/112, (Sitting), Pulse 63, (Brachial), Resp 20, Temp 37.2, (Tympanic), Pain 8, O2 Sat 99%, on Room Air, Time 1/15/2010 20:58.
(20:58 NAMC)

DIAGNOSIS (22:26 AJB)
FINAL: PRIMARY: **Abdominal pain.**

VITAL SIGNS
VITAL SIGNS: BP: 195/112 (Sitting), Pulse: 63 (Brachial), Resp: 20, Temp: 37.2 (Tympanic), Pain: 8, O2 sat: 99% on Room Air, Time: 1/15/2010 20:58. (20:58 NAMC)
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CURRENT MEDICATIONS (21:06 NAMC)
Patient not taking any medications

HPI ABDOMINAL PAIN (22:24 AJB)
CHIEF COMPLAINT: Patient presents for the evaluation of **abdominal pain, vomiting.**
HISTORIAN: History obtained from patient.
TIME COURSE MALE: **Onset of symptoms reported as gradual,** Onset was **days prior to arrival , Patient currently has symptoms.**
LOCATION MALE: **Pain in lower abdomen,** Radiation is not present.

[redacted]

MOUNT SINAI ED
NURSING SUMMARY

SEVERITY: Maximum severity is **moderate**, Currently **symptoms are mild.**
ASSOCIATED WITH: **Associated with abdominal pain**, No recent antibiotic use, No bright red blood per rectum, No associated chills, No associated constipation, No associated diarrhea, No associated fever, No associated flank pain, No groin pain, No hematemesis, Not associated with hematuria, No associated loss of appetite, No melena, **Associated with nausea**, No associated night sweats, No testicular pain, No associated trauma, No recent travel, **Associated with inability to tolerate P.O. fluids**, No associated UTI Symptoms, **Associated with vomiting.**
RISK FACTORS MALE: AAA risk factors N/A for this patient, Torsion testicle risk factors N/A for this patient.
EXACERBATED BY: Patient's condition exacerbated by nothing.
RELIEVED BY: Patient's condition relieved by **nothing.**

KNOWN ALLERGIES
Aspirin

MEDICATION ADMINISTRATION SUMMARY

Drug Name	Dose Ordered	Route	Status	Time
Sodium Chloride 0.9%, Intravenous	1L WIDE AND 100 mL/hr	IV infusion	Given	22:23 1/15/2010
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Detailed record available in Medication Service section.

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[redacted]

MOUNT SINAI ED
NURSING SUMMARY

[redacted]

ASSESSMENT: ABDOMEN WITH PROCEDURES (Sat Jan 16, 2010 00:58 NBLB)

CONSTITUTIONAL: History obtained from patient, Patient is cooperative, Patient is alert and oriented x 3, Patient's skin is warm and dry, Patient's mucous membranes are moist and pink, Patient arrives to treatment area via EMS, Patient with steady gait, Patient appears in pain distress.
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NURSING PROCEDURE: ADMISSION (Sat Jan 16, 2010 01:14 NBLB)

TIME: Report called at 1:14, Patient admitted to room 9c - 223a, Patient acuity level was urgent, Patient admitted to, med-surg unit, Report called/faxed to christian, rn, Provided opportunity to answer questions, Patient transported via, cart, Accompanied by, transport, Belongings are, with patient.

NURSING PROCEDURE: BEDSIDE TESTING (22:09 TKS)

CLINITEK 50(URINE DIPSTICK): Color is Yellow, pH is 7.0, Glucose negative, Protein positive, trace, Bilirubin positive, Large, Urobilinogen is 1.0, Ketone positive, >, Nitrate Negative, Specific Gravity 1.015, Leukocytes negative, Occult Blood negative.

NURSING PROCEDURE: EKG CHART (22:18 TKS)

TIME: Patient's identity verified by, patient stating name, patient stating birth date, hospital ID bracelet, EKG was performed at 2210, 12 lead EKG Performed-left chest.

Key: [redacted]

[redacted]

MOUNT SINAI ED
PHYSICIAN SUMMARY

[redacted]

DIAGNOSIS (22:26 AJB)
FINAL: PRIMARY: **Abdominal pain.**

CURRENT MEDICATIONS (21:06 NAMC)
Patient not taking any medications

GREET (20:58)
GREET: Greet: Fri Jan 15, 2010 20:58.

HPI ABDOMINAL PAIN (23:24 AJB)
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RELIEVED BY: Patient's condition relieved by **nothing.**

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ENT: Ears normal to inspection, Nose examination normal, Mouth normal to inspection.
NECK: Normal ROM, No jugular venous distention, No meningeal signs, Cervical spine nontender.
RESPIRATORY CHEST: Chest is nontender, Breath sounds normal, No respiratory distress.
CARDIOVASCULAR: RRR, Heart sounds normal.
ABDOMEN: No pulsatile masses, No other masses, Bowel sounds normal, No

[redacted]

MOUNT SINAI ED
PHYSICIAN SUMMARY

[redacted]

distension, No peritoneal signs, No hernias, McBurney's point nontender, No Murphy's sign, Liver and spleen normal, **Tenderness, is diffuse, which is mild in intensity.**
BACK: There is no CVA Tenderness, There is no tenderness to palpation, Normal inspection.
UPPER EXTREMITY: Inspection normal, No cyanosis, No clubbing, No edema, Normal range of motion, Normal pulses.
LOWER EXTREMITY: Inspection normal.
NEURO: GCS is 15, No focal motor deficits, Speech normal, Memory normal.
SKIN: Skin is warm, Skin is dry, Skin is normal color.
PSYCHIATRIC: Oriented X 3, Normal affect, Normal insight, Normal concentration.

ATTENDING

ADDITIONAL NOTES: 30M
INPT WHITE PLAINS HOSP
TRANSFEREED WITH EMS TO MSH ED
SURG AWARE OF TRANSFER, NGUYEN
ED PERSONNEL NOT AWARE
HARD COPY MED RECORDS REVIEWED
LAB RESULTS AND MED ORDERS
SINGLE CT READ WITH FINDINGS CW SBO
DW SURGERY
THEY WILL SEE PT IN ED
IV ACCESS
LABS FOR PRE OP AND ABD EVAL
NPO
IVF. (21:33 AJB)
?? DX AT WHITE PLAINS
REF TO SINAI
PROBS WITH HOSP TO JHOSP TRANSFER....PT TO ED
SEEN BY SURG IN ED....NO DW ED ATTENDING
WILL HYDRATE AND ADMIN PAIN MEDS. (21:55 AJB)

[redacted]

[redacted]

MOUNT SINAI ED
CURRENT MED LIST

[redacted]

CURRENT MEDICATIONS
Patient not taking any medications

PRESCRIPTION
No recorded prescriptions

Key:
[redacted]

[redacted]

MOUNT SINAI ED
RESULTS

[redacted]

ATTENDING

ADDITIONAL NOTES: 30M
INPT WHITE PLAINS HOSP
TRANSFEREED WITH EMS TO MSH ED
SURG AWARE OF TRANSFER, NGUYEN
ED PERSONNEL NOT AWARE
HARD COPY MED RECORDS REVIEWED
LAB RESULTS AND MED ORDERS
SINGLE CT READ WITH FINDINGS CW SBO
DW SURGERY
THEY WILL SEE PT IN ED
IV ACCESS
LABS FOR PRE OP AND ABD EVAL
NPO
IVF.
?? DX AT WHITE PLAINS
REF TO SINAI
PROBS WITH HOSP TO JHOSP TRANSFER....PT TO ED
SEEN BY SURG IN ED....NO DW ED ATTENDING
WILL HYDRATE AND ADMIN PAIN MEDS.

[redacted]

Mount Sinai ED
EMERGENCY FLOW SHEET RECORD
Name: [redacted] **Age: 30Y MR** [redacted] **Acct:** [redacted]

VITAL SIGNS	TKAS	TKS	NAMC
TIME	1/15/2010 23:58	1/15/2010 22:28	1/15/2010 20:58
BP	164/107	178/110 (Lying)	195/112 (Sitting)
PULSE	104	71	63 (Brachial)
RESP	20	18	20
TEMP	37	37.4 (Tympanic)	37.2 (Tympanic)
PAIN	2	2	8
O2 SAT	98% on Room Air	95% on Room Air	99% on Room Air

[redacted]

H&P

The Mount Sinai Hospital
One Gustave L. Levy Place
New York, NY 10029

[redacted]
ADDRESSOGRAPH STAMP

Department of Surgery

☑ Consultation ☐ Initial Hospital Care

Consult requested by: ED Consult to: Dr. Scott Nguyen / Surgery

Date/Time: 1/15/10

CC: Abdominal Pain

HPI (location, quality, timing, severity, duration, context, modifying factors, assoc. signs/symptoms): *Address at least 4*

35 y/o ♂ with no PMH, presents with a 3-day h/o suprapubic abdominal pain. Pain partially relieved by meds. ⊖nausea, vomiting with pain, meds. ⊖BM, ⊖flatus x 3 days. Receiving ABx x 3 days.

Review of Systems:

Address at least 10 systems

	WNL	Comments
Constitutional	✓	
Eyes	✓	
ENT	✓	
Cardiovascular		⊖chest pain
Respiratory		⊖SOB
GI		see HPI
GU		⊕difficulty voiding x 3 days.
Skin	✓	
Neuro	✓	
Endocrine	✓	
Musculoskeletal	✓	
Heme/Lymph	✓	
Allergic/Immune	✓	
Psych	✓	

PMH: none

PSH: R inguinal hernia repair

Family History: ☑ non-contrib

Social History: ETOH +/- smoking +/- IVDA +/-

Allergies: ASA (swelling (facial))

Meds: none

☑ All other negative unless described:

BP: 195/112 HR: 63 RR: 20 Temp: 37.2 O2 sat: on type of O2 therapy:

Laboratory Data:

13 | 17.2 | 197
49.3

136 | 98 | 8
3.2 | 24 | 1.0 | 110

134 | 27.2
1.0

AG 5.1
Tbili 0.8
Dbili 0.2
Alk Phos 61
AST 41
ALT 61

Radiological results:

CT abd: ? colitis

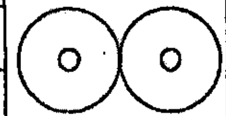
[redacted]

ADDRESSOGRAPH STAMP

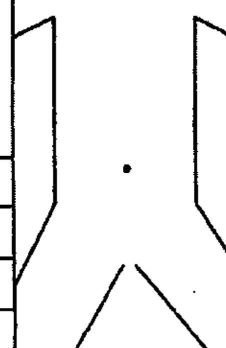
Physical Examination: *Address at least 8 systems*

	WNL	Findings – Pertinent pos and neg
Constitutional		[✓] well appearing
Eyes		[] PEERLA [] EOMI [] anicteric
Cardiovascular		[✓] RRR [✓] nl S1S2 [✓] no periph edema [✓] nl periph pulses
Respiratory		[✓] lungs CTA bilat
Chest/Breasts		[] no palp masses [] non-tender [] no nipple discharge Lymphadenopathy Y /N See fig.
GI/Rectal		[✓] soft [✓] non-tender [✓] no masses [✓] non-distended [✓] nl BS x 4 quads [✓] no hernias palp rectal: guaiac pos / (neg) [✓] nl tone [✓] no masses healed (R) IH surgical incision mild lower abd tend. See fig.
Musculoskeletal		[✓] nl ROM [] nl gait
Genitourinary		[✓] nl external genitalia [] nl testicular exam
Skin		[✓] nl pallor
Neurological		[] CN II – XII intact [] equal strength bilat
Hem/Lymph.		Lymphadenopathy Y / N Location:

Breast Figure



Abdomen figure



Assessment and Plan:

35 y/o ♂ with a 3-day h/o lower abdominal pain

- CT from OSH suggesting colitis
- will keep NPO, IVF
- pain control
- Admit to Surgery IV
- Plans discussed with Dr. Nguyen, ED attending Dr. Br

Date/Time: 1/15/10 Provider Signature: [signature] (MD)/NP/PA

Print Name: CHERNOGUZ Dict code: 64768 Pager: 3670

Attending statement:

Pt seen & examined. Agree w/ above. Lower abd pain for past 3-4 days. Ø diarrhea. CT (OSH) w/ thickening rectosigmoid (collapsed). Possible colitis. Needs admission IVF. IV Abx Resusc. GI to see.

Attg signature: [signature] Print Name: NGUYEN Date/Time: 1/16/10 Dict code: 14150

[redacted] M 30
DOB: [redacted]
ADM: 01/15/10
SERV: MED N09E 9315A
[redacted] 14150 FC: CI

TEST RESULTS SUMMARY
-PERMANENT CHART COPY-
SUMMARY: 01/15 22:28 TO 23:59 01/28

* = NEW RESULT. H = HIGH RESULT. L = LOW RESULT.
I = INCORRECT RESULT. C = CORRECT RESULT.

CHEMISTRY

TEST	01/15 22:25	01/16 04:22	01/16 11:47	01/17 04:24	RANGE/UNITS
GLUCOSE	. .	115	121 H	151 H	60-120 MG/DL
SODIUM	. .	133 L	131 L	129 L	135-145 MEQ/L
POTASSIUM	. .	3.7	4.1	4.1	3.5-5 MEQ/L
CHLORIDE	. .	97	95 L	92 L	96-108 MEQ/L
CO2 TOTAL	. .	21.6 L	24.6	26.4	22-32 MEQ/L
BUN	. .	8 L	8 L	10 L	11-25 MG/DL
CREATININE	. .	0.9	1.0	0.8	0.7-1.2 MG/DL
TBILI	0.8	. .	0.7	0.6	0.1-1.2 MG/DL
DBILI	0.2	. .	0.2	0.2	0-0.8 MG/DL
T.PROTEIN	. .	. .	7.7	7.6	6.0-8.3 G/DL
ALBUMIN	5.1	. .	4.8	4.7	3.4-5.2 G/DL
CALCIUM	. .	. .	9.4	9.2	8.5-11 MG/DL
PHOSPHORUS	. .	. .	2.3 L	2.8	2.4-4.7 MG/DL
ALK PHOSPH	61	. .	58	58	30-110 U/L
GAMMA GTP	. .	. .	14	10	10-54 UNITS
ALT (SGPT)	61 H	. .	61 H	60 H	1-53 U/L
AST (SGOT)	41	. .	37	39	1-50 U/L
LD (LDH)	. .	. .	182	216	100-220 U/L
AMYLASE	. .	. .	45	53	30-300 U/L
MAGNESIUM	. .	. .	1.8	1.8	1.5-2.5 MG/DL

TEST	01/18 05:08	RANGE/UNITS
GLUCOSE	114	60-120 MG/DL
SODIUM	128 L	135-145 MEQ/L
POTASSIUM	4.0	3.5-5 MEQ/L
CHLORIDE	93 L	96-108 MEQ/L
CO2 TOTAL	26.0	22-32 MEQ/L
BUN	10 L	11-25 MG/DL
CREATININE	0.9	0.7-1.2 MG/DL

CONTINUED

[redacted] M 30
DOB [redacted]
ADM:01/15/10
SERV:MED N09E 9315A
MD:NGUYEN, SCOTT MD 14150 FC:CI

TEST RESULTS SUMMARY
-PERMANENT CHART COPY-
SUMMARY: 01/15 22:28 TO 23:59 01/28

HEMATOLOGY

TEST	01/15 22:25	01/16 04:22	01/17 04:24	01/17 16:58	RANGE/UNITS
NRBC #	0.00	. .	0.00	. .	>0.0 X 10 3/UI
NRBC %	0.00	. .	0.00	. .	>0.0 %
WBC	13.0 H	11.9 H	11.1 H	12.9 H	5-11.0 X 1,000
RBC	5.64	5.21	5.58	5.18	4.5-6 X 10 6/U
HGB	17.2 H	16.1	17.1 H	16.0	13.9-16.3 G/DL
HCT	49.3	44.7	48.3	44.4	42-55 %
MCV	87.4	85.9	86.6	85.6	80-100 FL
MCH	30.5	31.0	30.6	30.8	27-32 PG
MCHC	34.8	36.1	35.3	36.0	32.0-36.5 G/DL
RDW	12.7	12.8	12.5	12.8	11.5-14.5 %
MPV	8.4	9.0	8.0	8.3	7.4-10.4 FL
NEUTROPHIL	11.0 H	. .	9.3 H	. .	1.9-8 X 1,000
LYMPHOCYTE	0.9 L	. .	0.7 L	. .	1-4.5 X 1,000
MONOCYTE	1.2 H	. .	1.2 H	. .	0.20-1.0 X 1,0
EOSINOPHIL	0.0	. .	0.0	. .	0-0.8 X 1,000
BASOPHIL	0.0	. .	0.0	. .	0-0.2 X 1,000
NEUT %	84.1 H	. .	83.3 H	. .	40.0-74.0 %
LYMPH %	6.9 L	. .	5.9 L	. .	15.0-50.0 %
MONO %	8.9	. .	10.6	. .	2.0-11.0 %
EOS %	0.0 L	. .	0.1 L	. .	1.0-7.0 %
BASO %	0.1	. .	0.1	. .	0.0-1.0 %

TEST	01/18 05:08	RANGE/UNITS
WBC	8.9	5-11.0 X 1,000
RBC	4.68	4.5-6 X 10 6/U
HGB	14.4	13.9-16.3 G/DL
HCT	40.5 L	42-55 %
MCV	86.6	80-100 FL
MCH	30.8	27-32 PG
MCHC	35.6	32.0-36.5 G/DL
RDW	12.6	11.5-14.5 %
MPV	8.2	7.4-10.4 FL

CONTINUED

[redacted]

[redacted]

15-JAN-2010 22:14:31

THE MOUNT SINAI MEDICAL CENTER

Male Caucasian

Room:
Loc:110

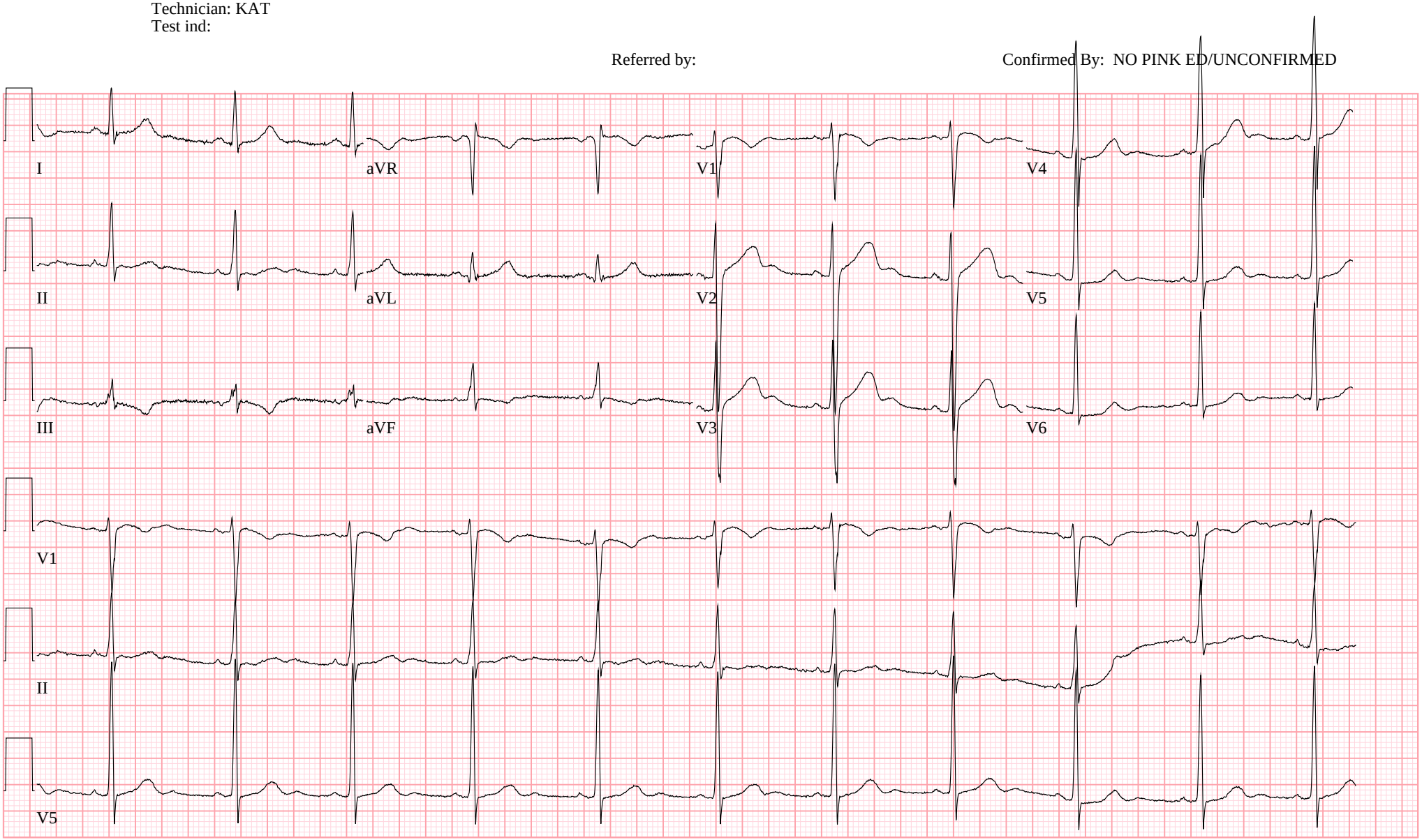
Vent. rate	66	BPM
PR interval	128	ms
QRS duration	88	ms
QT/QTc	424/444	ms
P-R-T axes	9 42	-10

NORMAL SINUS RHYTHM
T WAVE ABNORMALITY, CONSIDER INFERIOR ISCHEMIA
ABNORMAL ECG

Technician: KAT
Test ind:

Referred by:

Confirmed By: NO PINK ED/UNCONFIRMED



25mm/s 10mm/mV 150Hz 7.1.1 12SL 237 CID: 5

EID:4 EDT: 15:51 19-JAN-2010 ORDER:

OPERATION: DIAGNOSTIC LAPAROSCOPY, LYSIS OF ADHESION, RUNNING OF ENTIRE SMALL AND LARGE BOWEL, APPENDECTOMY.
SURGEON: SCOTT NGUYEN, M.D.
ASSISTANT: 1ST DR. LEUNG.
ANESTHESIA: GENERAL ANESTHESIA.
COMPLICATIONS: NONE.
FINDINGS: MULTIPLE ADHESIONS OF OMENTUM TO RIGHT COLON AND RIGHT ABDOMEN, MODERATELY DISTENDED SMALL BOWEL DIFFUSELY, NORMAL APPENDIX.
INDICATIONS: The patient is a [redacted] male with a history of acute lower abdominal pain for the past 5 days. He came to the Emergency Room twice in [redacted] without resolution of the pain. He came to [redacted] two days ago with the pain persisting. A review of his CAT scans from [redacted] revealed no frank pathology.
The patient underwent a flexible sigmoidoscopy upon arrival here at Mount Sinai by [redacted] which revealed no frank colitis or irritation of the left colon. As his pain persisted, he required more and more narcotic. A CAT scan again revealed no frank pathology. We therefore felt that a diagnostic laparoscopy was the only viable option to rule out abdominal catastrophe in this young man.
PROCEDURE: The patient was taken to the Operating Room and placed in a supine position after adequate general anesthesia was established. A Foley catheter was sterilely placed. He was prepped and draped in the usual surgical fashion. We used a Hasson technique to enter the abdominal cavity. We then placed two 5 mm ports, one in the suprapubic region and one in the left abdomen. We also placed one more in the epigastric region.
The abdominal cavity was explored in the pelvis. The rectosigmoid did not appear to have any pathology. We went over to the right colon appendix. It was retrocecal, however, appeared normal. In the right colon, the omentum was extremely adherent to the right colon and the pericolonic structures and the right colonic gutter.
On lifting up the omentum, we noticed some dilated loops of small bowel which were fairly diffuse with no frank transition zone adjacent to these adhesions. We, thought, that perhaps these adhesions and the associated bowel complications could, perhaps, be the cause of the symptoms.
The adhesions of the right abdomen was sharply divided in order to

free up the omentum and the right colon. We spent approximately one hour on this lysis of adhesions and the running of the small bowel in its entirety to follow for any evidence of bowel destruction or small bowel lesions and there were none.

The appendix appeared without irritation and inflammation and was in a retrocecal position. We dissected the appendix away from the retroperitoneal structures and divided the mesoappendix with a white load stapler and divided the base of the appendix at the cecum with a blue load Endo-GIA.

The abdomen was then irrigated and assured to be adequately hemostatic. The fluid was aspirated. We again took a look around the abdomen without any other pathology. After all ports were removed under direct vision, the umbilical port was closed using #0 Vicryl on a UR6. The patient tolerated the procedure well.

Unreviewed

[redacted]

hyp

D:01/17/2010 T:01/17/2010 [redacted]

[redacted]

cc: [redacted]

[redacted]

THE MOUNT SINAI HOSPITAL
NEW YORK, NEW YORK

CONSULTATION REPORT

REQUESTED BY: SURGERY – NGUYEN M.D.
SIGNATURE OF PHYSICIAN & SERVICE

DICTATION NO: ______

TO: GI – PALLEN(?) M.D.
CONSULTING PHYSICIAN OR SERVICE

[redacted]

NGUYEN, SCOTT 1/15/2010
14150
N09C

DATE
NAME
UNIT NO./SEX/D.O.B.
SERIAL NO./LOCATION
PHYSICIAN/SERVICE
DATE

REQUESTING PHYSICIAN

REASON FOR CONSULTATION: abd pain

[redacted] no significant PMH/PSH developed lower abdominal pain 3 days ago. Has been in White Plains ER twice over last 3 days. Rx'd abx + pain meds. CT x2 shows severe rectosigmoid thickening (on my review) without clear pericolonic

MEDS
MSO4
Zofran

CONSULTANT'S FINDINGS: (HISTORY AND PHYSICAL)

inflammatory changes
+ vomited x2 ↓ BM in 3 days
decreased diet c̄ ... 2 weeks ago
deny prior GI history
PMH/PSH: see above
All: ∅

LABS
133 | 97 | 8 / 3.7 | 22 | 0.8 < 115
11.9 > 16.1 < 167

PE VS: T37.4 HR ... 112/60
comfortable
CV –
...
soft NT ND
distended ...

Imp ? colitis
No evidence diverticulitis on scan

Plan – bedside flex sig this AM to further eval

OPINION AND RECOMMENDATIONS:

– Risks (infection, perforation, bleeding, need for surgery) benefits, alternatives discussed with patient

DATE 1/16/10 TIME ______ SIGNATURE OF CONSULTANT [redacted] TITLE OF CONSULTANT

CONSULTING PHYSICIAN

D-I-A-20
Rev. 7/97

PLEASE DO NOT WRITE IN THIS SPACE-WRITE ON THIS SIDE OF PAPER ONLY

CHART COPY

[redacted]

MOUNT SINAI ED
PRIMARY

[redacted]

Patient Data

Complaint: Abd Pain
Triage Time: Sun Jan 24, 2010 16:42
Urgency: ESI Level 3
Bed: ED NORTH 03A
Initial Vital Signs: 1/24/2010 16:38
BP:178/99
P:108
O2 sat:100 on Room Air

ED Attending: [redacted]
Primary RN: [redacted]

R:20
T:36.0
Pain:

TRIAGE (Sun Jan 24, 2010 16:42 NLLB)
COMPLAINT: Abd Pain. (Sun Jan 24, 2010 16:42 NLLB)
PROVIDERS: TRIAGE NURSE: [redacted] NLLB)
ADMISSION: URGENCY: ESI Level 3, ADMISSION SOURCE: Home, TRANSPORT: Ambulatory, BED: AERNORTH. (Sun Jan 24, 2010 16:42 NLLB)
PATIENT: NAME: [redacted] GENDER: male, DOB: [redacted] TIME OF GREET: Sun Jan 24, 2010 16:26, LANGUAGE: English, Isolation Precaution: .None Needed, abuse/assault: Deferred, Emerg. Surveillance: deferred, MEDICAL RECORD NUMBER: [redacted], ACCOUNT NUMBER: [redacted] PMD/PCP: NONE,. (Sun Jan 24, 2010 16:42 NLLB)
PREVIOUS VISIT ALLERGIES: Aspirin. (Sun Jan 24, 2010 16:42 NLLB)
ASSESSMENT: s/p abd surg last sunday. now with increased abd pain x 2 days. taking percocet with little effect. (Sun Jan 24, 2010 16:42 NLLB)
TREATMENT IN TRIAGE (Sun Jan 24, 2010 16:42 NLLB)
VITAL SIGNS: BP 178/99, Pulse 108, Resp 20, Temp 36.0, O2 Sat 100, on Room Air. Time 1/24/2010 16:38. (16:38 NLLB)

CALL IN (15:47 XRF)
NOTES: **ADULT PT CALLED IN BY [redacted] WITH A C/O ABD PAIN--PKEASE NOTI[redacted] UPON EVALUATION VIA [redacted]--PT ADMISSION IS NOT EXPECTED.**
CALL IN: Call In: Sun Jan 24, 2010 15:47.

GREET (16:26)
GREET: Greet: Sun Jan 24, 2010 16:26.

CURRENT MEDICATIONS (16:43 NLLB)
percocet

DIAGNOSIS (20:48 EMCI)
FINAL: PRIMARY: **Abdominal pain.**

PAST MEDICAL HISTORY (Sun Jan 24, 2010 16:42 NLLB)
NOTES: **Nursing records reviewed, Agree with nursing records, Old chart reviewed, Unable to obtain complete past history due to patient's condition.**
MEDICAL HISTORY: No past medical history, **No past medical history.**
PSYCHIATRIC HISTORY: **No previous psychiatric history.**
SURGICAL HISTORY: **Patient's previous surgical history is not relevant to the case.**
SOCIAL HISTORY: **Denies alcohol abuse, Denies tobacco abuse, Denies drug abuse, Lives with others.**
FAMILY HISTORY: **Family history is not contributory to this case.**

[redacted]

MOUNT SINAI ED
PRIMARY

[redacted]

HPI ABDOMINAL PAIN (17:11 EHC2)

NOTES: **30M with h/o abdominal pain since 1/12, s/p 3 abd cts, s/p sigmoidoscopy, s/p diagnostic laparoscopy with lysis of adhesions and appendectomy 1/17, now c/o of recurrence of band like lower abdominal pain for the last 2 days.**

CHIEF COMPLAINT: Patient presents for the evaluation of **abdominal pain**.

HISTORIAN: History obtained from patient, History obtained from family.

TIME COURSE MALE: **Onset of symptoms reported as gradual**, Onset was **2 days prior to arrival** , **Patient currently has symptoms.**

QUALITY: Pain is **aching**.

LOCATION MALE: **Pain in lower abdomen**, Radiation is not present.

SEVERITY: Maximum severity is **mild**, Currently **symptoms are mild.**

ASSOCIATED WITH: **Associated with abdominal pain**, No recent antibiotic use, No bright red blood per rectum, No associated chills, No associated constipation, No associated diarrhea, No associated fever, No associated flank pain, No groin pain, No hematemesis, Not associated with hematuria, No associated loss of appetite, No melena, No associated nausea, No associated night sweats, No testicular pain, No associated trauma, No recent travel, Patient is able to tolerate P.O. fluids, No associated UTI Symptoms, No associated vomiting, No associated weight change.

RISK FACTORS MALE: No AAA risk factors, No torsion testicle risk factors.

EXACERBATED BY: Patient's condition exacerbated by nothing.

RELIEVED BY: Patient's condition relieved by **nothing**.

ATTENDING (18:17 AMNO)

ADDITIONAL NOTES: Pt is [redacted] w/ complicated recent abd history.
Presented for eval initially 1/09 for abd pain-- seen by GI & surgery w/ eval including sigmoidoscopy & CT scan x 3. Pt eventually w/ ex lap 1/17 (see above) by Gen Surg @ MSH for persistent pain-- and s/p LOA
Pt represents for pain, not controlled by percocet.
+ tol pos
VS noted
Awake & mentating clearly-- but uncomfortable
No resp diostress
abd sof/ ND— + lower abd discomfrot w/ palp
D/w team— Unclear of etiology for pain.
Plan for labs, IVF, pain management & GI & Surgery eval
Re-eval post observation.

DOCTOR NOTES

TEXT: **SURGEON NAME: SCOTT NGUYEN, MD**
PROCEDURE DATE: 01/17/2010
ADMIT DATE: 01/15/2010
DISCH DATE:
PREOPERATIVE DIAGNOSIS: ACUTE ABDOMINAL PAIN.
POSTOPERATIVE DIAGNOSIS: INTESTINAL ADHESIONS.
OPERATION: DIAGNOSTIC LAPAROSCOPY, LYSIS OF ADHESION, RUNNING OF ENTIRE SMALL AND LARGE BOWEL, APPENDECTOMY.
SURGEON: SCOTT NGUYEN, M.D. . (17:24 AMNO)

D/W: Discussed with appropriate consultants, Surgery, Text: **will evaluate the patient.** (17:26 EHC2)

TEXT: **GI and surgery consult said patient may d/c with 4mg po dilaudid q4 hours if a trial of po dilaudid**

[redacted]

controls his pain here. He would follow up with his surgeon tomorrow. If patient's pain not controlled, will need an admit to surgery for pain control. (19:07 EHC2)
pt with continued pain after PO pain meds
give IV dilaudid
spoke with surg
admit to surg service for cont managmenet and pain control. (20:58 EMC1)

VITAL SIGNS

VITAL SIGNS: BP: 178/99, Pulse: 108, Resp: 20, Temp: 36.0, O2 sat: 100 on Room Air, Time: 1/24/2010 16:38. (16:38 NLLB)
Pain: 9, Time: 1/24/2010 20:37. (20:37 NJM1)
BP: 182/106, Pulse: 90, Resp: 20, Temp: 37.2, Pain: 9, O2 sat: 97 on Room Air, Time: 1/24/2010 21:05. (21:05 TSD1)

KNOWN ALLERGIES

Aspirin, Morrin

MEDICATION ADMINISTRATION SUMMARY

Drug Name	Dose Ordered	Route	Status	Time
Morphine Sulfate	6 milligram(s)	IV Push	Cancelled	17:16 1/24/2010
Dilaudid	2 milligram(s)	IVPB	Given	20:36 1/24/2010
Dilaudid	4 milligram(s)	PO	Given	19:41 1/24/2010
Dilaudid	6 milligram(s)	PO	Given	18:48 1/24/2010
Sodium Chloride 0.9%, Intravenous	125 ml/hr mL/hr	IV infusion	Given	18:18 1/24/2010
Dilaudid	1 milligram(s)	IVPB	Given	17:21 1/24/2010
Sodium Chloride 0.9%, Intravenous	1 liter(s)	IV infusion	Given	17:00 1/24/2010

Detailed record available in Medication Service section.

ORDERS

GEM 3000 by Curtis, MD, Henry for Curtis, MD, Henry on Sun Jan 24, 2010 16:58 Status: Done by Amores, RN, Nerissa Sun Jan 24, 2010 17:10
Type and Screen by Curtis, MD, Henry for Curtis, MD, Henry on Sun Jan 24, 2010 16:58 Status: Done by System Sun Jan 24, 2010 21:29
URINALYSIS by Curtis, MD, Henry for Curtis, MD, Henry on Sun Jan 24, 2010 16:58 Status: Done by System Sun Jan 24, 2010 18:28
CBC, PLT & DIFF by Curtis, MD, Henry for Curtis, MD, Henry on Sun Jan 24, 2010 16:58 Status: Done by System Sun Jan 24, 2010 18:29
PT by Curtis, MD, Henry for Curtis, MD, Henry on Sun Jan 24, 2010 16:58 Status: Done by System Sun Jan 24, 2010 19:02
NPO by Curtis, MD, Henry for Curtis, MD, Henry on Sun Jan 24, 2010 16:58 Status: Active
POC Urinalysis by Curtis, MD, Henry for Curtis, MD, Henry on Sun Jan 24, 2010 16:58 Status: Done by Amores, RN, Nerissa Sun Jan 24, 2010 17:10
ABDOMINAL PAIN PANEL by Curtis, MD, Henry for Curtis, MD, Henry on Sun Jan 24, 2010 16:58 Status: Done by System Sun Jan 24, 2010 19:10
ER VENOUS PANEL by Curtis, MD, Henry for Curtis, MD, Henry on Sun Jan 24, 2010 16:58 Status: Done by System Sun Jan 24, 2010 18:38
PTT by Curtis, MD, Henry for Curtis, MD, Henry on Sun Jan 24, 2010 16:58 Status: Done by System Sun Jan 24, 2010 19:03

[redacted]

MOUNT SINAI ED
PHYSICIAN SUMMARY

[redacted]

DIAGNOSIS (20:48 EMC1)
FINAL: PRIMARY: **Abdominal pain.**

CURRENT MEDICATIONS (16:43 NLLB)
percocet

GREET (16:26)
GREET: Greet: Sun Jan 24, 2010 16:26.

HPI ABDOMINAL PAIN (17:11 EHC2)
NOTES: [redacted] **with h/o abdominal pain since 1/12, s/p 3 abd cts, s/p sigmoidoscopy, s/p diagnostic laparoscopy with lysis of adhesions and appendectomy 1/17, now c/o of recurrence of band like lower abdominal pain for the last 2 days.**
CHIEF COMPLAINT: Patient presents for the evaluation of **abdominal pain.**
HISTORIAN: History obtained from patient, History obtained from family.
TIME COURSE MALE: **Onset of symptoms reported as gradual**, Onset was **2 days prior to arrival , Patient currently has symptoms.**
QUALITY: Pain is **aching.**
LOCATION MALE: **Pain in lower abdomen**, Radiation is not present.
SEVERITY: Maximum severity is **mild**, Currently **symptoms are mild.**
ASSOCIATED WITH: **Associated with abdominal pain**, No recent antibiotic use, No bright red blood per rectum, No associated chills, No associated constipation, No associated diarrhea, No associated fever, No associated flank pain, No groin pain, No hematemesis, Not associated with hematuria, No associated loss of appetite, No melena, No associated nausea, No associated night sweats, No testicular pain, No associated trauma, No recent travel, Patient is able to tolerate P.O. fluids, No associated UTI Symptoms, No associated vomiting, No associated weight change.
RISK FACTORS MALE: No AAA risk factors, No torsion testicle risk factors.
EXACERBATED BY: Patient's condition exacerbated by nothing.
RELIEVED BY: Patient's condition relieved by **nothing.**

ATTENDING (18:17 AMNO)
ADDITIONAL NOTES: Pt is 30yoM w/ complicated recent abd history.
Presented for eval initially 1/09 for abd pain— seen by GI & surgery w/ eval including sigmoidoscopy & CT scan x 3. Pt eventually w/ ex lap 1/17 (see above) by Gen Surg @ MSH for persistent pain-- and s/p LOA
Pt represents for pain, not controlled by percocet.
+ tol pos
VS noted
Awake & mentating clearly-- but uncomfortable
No resp diostress
abd soft/ ND-- + lower abd discomfrot w/ palp
D/w team-- Unclear of etiology for pain.

[redacted]

MOUNT SINAI ED
PHYSICIAN SUMMARY

Plan for labs, IVF, pain management & GI & Surgery eval
Re-eval post observation.

DOCTOR NOTES
TEXT: **SURGEON NAME:** [redacted]
PROCEDURE DATE: 01/17/2010
ADMIT DATE: 01/15/2010
DISCH DATE:
PREOPERATIVE DIAGNOSIS: ACUTE ABDOMINAL PAIN.
POSTOPERATIVE DIAGNOSIS: INTESTINAL ADHESIONS.
OPERATION: DIAGNOSTIC LAPAROSCOPY, LYSIS OF ADHESION, RUNNING OF ENTIRE
SMALL AND LARGE BOWEL, APPENDECTOMY.
SURGEON: SCOTT NGUYEN, M.D. . (17:24 AMNO)
D/W: Discussed with appropriate consultants, Surgery, Text: will evaluate the patient. (17:26 EHC2)
TEXT: **GI and surgery consult said patient may d/c with 4mg po dilaudid q4 hours if a trial of po dilaudid controls his pain here. He would follow up with his surgeon tomorrow. If patient's pain not controlled, will need an admit to surgery for pain control.** (19:07 EHC2)
pt with continued pain after PO pain meds
give IV dilaudid
spoke with surg
admit to surg service for cont managmenet and pain control. (20:58 EMC1)

RESULTS (17:26 AMNO)

Measurement	Result	Units	Range
BLOOD GAS/ELEC PROF-VEN Sun Jan 24, 2010 17:10			
WB GLUCOSE-VEN (POCT)	133	MG/DL	60-120
WB LACTATE-VEN (POCT)	1.5	MMOL/L	0.5-2.2
WB NA - VEN (POCT)	130	MEQ/L	135-145
WB K - VEN (POCT)	3.6	MEQ/L	3.5-5.0
WB CA++ - VEN(POCT)	1.15	MMOL/L	1.14-1.29
BASE EX - VEN(POCT)	2.7	MMOL/L	-3.0-3.0
O2 SAT - VEN (POCT)	35	%	0-75
HEMATOCRIT-VEN(POCT)	46	%	42-55
pO2 - VEN (POCT)	21	MM HG	20-50
HCO3 - VEN (POCT)	28	MEQ/L	20-27
TOT CO2 - VEN(POCT)	29	MEQ/L	24-32
PATIENT TEMP(POCT)	37.0	oC	
pH - VEN (POCT)	7.41		7.33-7.43
pCO2 - VEN (POCT)	44	MM HG	40-50
PATIENT TEMP(POCT)	37.0	oC	
pH - VEN (POCT)	7.41		7.33-7.43
pCO2 - VEN (POCT)	44	MM HG	40-50
pO2 - VEN (POCT)	21	MM HG	20-50
HCO3 - VEN (POCT)	28	MEQ/L	20-27
TOT CO2 - VEN(POCT)	29	MEQ/L	24-32
BASE EX - VEN(POCT)	2.7	MMOL/L	-3.0-3.0
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HEMATOCRIT-VEN(POCT)	46	%	42-55
WB NA - VEN (POCT)	130	MEQ/L	135-145

DC 3AA

Mount Sinai ED
EMERGENCY FLOW SHEET RECORD
[redacted]

VITAL SIGNS	TED1	NJM1	NCEB
TIME	1/24/2010 21:05	1/24/2010 20:37	1/24/2010 16:38
BP	182/106		178/99
PULSE	90		108
RESP	20		20
TEMP	37.2		36.0
PAIN	9	9	
O2 SAT	97 on Room Air		100 on Room Air

[redacted]

MOUNT SINAI ED
NURSING SUMMARY

[redacted]

TRIAGE (Sun Jan 24, 2010 16:42 NLLB)
COMPLAINT: Abd Pain. (Sun Jan 24, 2010 16:42 NLLB)
PROVIDERS: TRIAGE NURSE: [redacted]
(Sun Jan 24, 2010 16:42 NLLB)
ADMISSION: URGENCY: ESI Level 3, ADMISSION SOURCE: Home, TRANSPORT: Ambulatory, BED: AERNORTH.
(Sun Jan 24, 2010 16:42 NLLB)
PATIENT: NAME: [redacted] GENDER: male, DOB: [redacted] 1979, TIME OF GREET: Sun Jan 24, 2010 16:26, LANGUAGE: English, Isolation Precaution: None Needed, abuse/assault: Deferred, Emerg. Surveillance: [redacted]
PMD/PCP: NONE,. (Sun Jan 24, 2010 16:42 NLLB)
PREVIOUS VISIT ALLERGIES: Aspirin. (Sun Jan 24, 2010 16:42 NLLB)
ASSESSMENT: s/p abd surg last sunday. now with increased abd pain x 2 days. taking percocet with little effect. (Sun Jan 24, 2010 16:42 NLLB)
TREATMENT IN TRIAGE (Sun Jan 24, 2010 16:42 NLLB)
VITAL SIGNS: BP 178/99, Pulse 108, Resp 20, Temp 36.0, O2 Sat 100, on Room Air, Time 1/24/2010 16:38. (16:38 NLLB)

DIAGNOSIS (20:48 EMC1)
FINAL: PRIMARY: **Abdominal pain.**

VITAL SIGNS
VITAL SIGNS: BP: 178/99, Pulse: 108, Resp: 20, Temp: 36.0, O2 sat: 100 on Room Air, Time: 1/24/2010 16:38. (16:38 NLLB)
Pain: 9, Time: 1/24/2010 20:37. (20:37 NJM1)
BP: 182/106, Pulse: 90, Resp: 20, Temp: 37.2, Pain: 9, O2 sat: 97 on Room Air, Time: 1/24/2010 21:05. (21:05 TED1)

CURRENT MEDICATIONS (16:43 NLLB)
percocet

HPI ABDOMINAL PAIN (17:11 EHC2)
NOTES: **30M with h/o abdominal pain since 1/12, s/p 3 abd cts, s/p sigmoidoscopy, s/p diagnostic laparoscopy with lysis of adhesions and appendectomy 1/17, now c/o of recurrence of band like lower abdominal pain for the last 2 days.**
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MOUNT SINAI ED
NURSING SUMMARY

[redacted]

ASSOCIATED WITH: **Associated with abdominal pain**, No recent antibiotic use, No bright red blood per rectum, No associated chills, No associated constipation, No associated diarrhea, No associated fever, No associated flank pain, No groin pain, No hematemesis, Not associated with hematuria, No associated loss of appetite, No melena, No associated nausea, No associated night sweats, No testicular pain, No associated trauma, No recent travel, Patient is able to tolerate P.O. fluids, No associated UTI Symptoms, No associated vomiting, No associated weight change.
RISK FACTORS MALE: No AAA risk factors, No torsion testicle risk factors.
EXACERBATED BY: Patient's condition exacerbated by nothing.
RELIEVED BY: Patient's condition relieved by **nothing**.

KNOWN ALLERGIES

Aspirin, Motrin

MEDICATION ADMINISTRATION SUMMARY

Drug Name	Dose Ordered	Route	Status	Time
Morphine Sulfate	6 milligram(s)	IV Push	Cancelled	17:16 1/24/2010
Dilaudid	2 milligram(s)	IVPB	Given	20:36 1/24/2010
Dilaudid	4 milligram(s)	PO	Given	19:41 1/24/2010
Dilaudid	6 milligram(s)	PO	Given	18:48 1/24/2010
Sodium Chloride 0.9%, Intravenous	125 ml/hr mL/hr	IV infusion	Given	18:18 1/24/2010
Dilaudid	1 milligram(s)	IVPB	Given	17:21 1/24/2010
Sodium Chloride 0.9%, Intravenous	1 liter(s)	IV infusion	Given	17:00 1/24/2010

Detailed record available in Medication Service section.

ORDERS

GEM 3000 by Curtis, MD, Henry for Curtis, MD, Henry on Sun Jan 24, 2010 16:58 Status: Done by Amores, RN, Nerissa Sun Jan 24, 2010 17:10
Type and Screen by Curtis, MD, Henry for Curtis, MD, Henry on Sun Jan 24, 2010 16:58 Status: Done by System Sun Jan 24, 2010 21:29
URINALYSIS by Curtis, MD, Henry for Curtis, MD, Henry on Sun Jan 24, 2010 16:58 Status: Done by System Sun Jan 24, 2010 18:28
CBC, PLT & DIFF by Curtis, MD, Henry for Curtis, MD, Henry on Sun Jan 24, 2010 16:58 Status: Done by System Sun Jan 24, 2010 18:29
PT by Curtis, MD, Henry for Curtis, MD, Henry on Sun Jan 24, 2010 16:58 Status: Done by System Sun Jan 24, 2010 19:02
NPO by Curtis, MD, Henry for Curtis, MD, Henry on Sun Jan 24, 2010 16:58 Status: Active
POC Urinalysis by Curtis, MD, Henry for Curtis, MD, Henry on Sun Jan 24, 2010 16:58 Status: Done by Amores, RN, Nerissa Sun Jan 24, 2010 17:10
ABDOMINAL PAIN PANEL by Curtis, MD, Henry for Curtis, MD, Henry on Sun Jan 24, 2010 16:58 Status: Done by System Sun Jan 24, 2010 19:10
ER VENOUS PANEL by Curtis, MD, Henry for Curtis, MD, Henry on Sun Jan 24, 2010 16:58 Status: Done by System Sun Jan 24, 2010 18:38
PTT by Curtis, MD, Henry for Curtis, MD, Henry on Sun Jan 24, 2010 16:58 Status: Done by System Sun Jan 24, 2010 19:03

[redacted]

MOUNT SINAI ED
NURSING SUMMARY

ASSESSMENT: ABDOMEN WITH PROCEDURES (17:00 NNHA)

CONSTITUTIONAL: Patient arrives ambulatory with steady gait to treatment area, History obtained from patient, Patient is cooperative, Patient is alert and oriented x 3, Patient appears in no acute distress, Patient's skin is warm and dry, Patient's mucous membranes are moist and pink, **Patient appears in pain distress.**

ABDOMEN: Non-distended, Positive bowel sounds in 4 quads, Patient denies nausea, Patient denies vomiting, Patient denies diarrhea, Patient denies constipation, Patient denies flank tenderness, No pulsatile masses noted to abdomen, **Patient complains of pain to periumbilical area, Patient complains of pain to suprapubic area,** Pain described as **sharp, Pain is continuous,** On a scale 0-10 patient rates pain as 9, Pain non-radiating, **Tenderness noted to suprapubic area, Tenderness noted to periumbilical area.**

GENITOURINARY MALE: No complaint of pain, No discharge, No urinary complaints.

IV: Patient's identity verified by, patient stating name, patient stating birth date, hospital ID bracelet, Indications for procedure: fluid replacement, Indications for procedure: medication administration, Procedure performed at 1705, IV established, 20 gauge catheter inserted, into left antecubital, #1 site, in 1 attempt, 0.9NS 1 Liter hung, 1st bag hung, IV bolus of 1000 ml established, Rate of bolus, wide open, via primary tubing, via gravity tubing, Labs drawn at time of placement, Specimen labeled in the presence of the patient and sent to lab, After procedure, no swelling noted at site, After procedure, no drainage noted at site, After procedure, no redness, Emotional support needed and given, Patient tolerated procedure well.

NURSING PROCEDURE: ADMISSION

EQUIPMENT WITH PATIENT: nurse on floor wants to speak nurse. (21:28 NMD)

TIME: Report called at 2117, Patient admitted to room 314a 10e, Patient acuity level was urgent, Patient admitted to, med-surg unit, Report called/faxed to rn, myra, Provided opportunity to answer questions. (21:17 NMO)

Report called at 21:38, Patient admitted to room 10e - 314a, Patient acuity level was urgent, Patient admitted to, med-surg unit, Report called/faxed to joan, rn, Provided opportunity to answer questions, Patient transported via, cart, Accompanied by, transport, Belongings are, with patient. (21:38 NBLB)

NURSING PROCEDURE: BEDSIDE TESTING (17:10 TED1)

CLINITEK 50(URINE DIPSTICK): Color is Yellow, pH is 6.5, Glucose negative, Protein negative, Bilirubin negative, Urobilinogen is 0.2, Ketone positive, Trace, Nitrate Negative, Specific Gravity <, Leukocytes negative, Occult Blood negative.

RAPID STREP: Patient's identity verified by, hospital ID bracelet, Patient tolerated procedure well.

[redacted]

MOUNT SINAI ED
NURSING SUMMARY

[redacted]

NURSING PROCEDURE: IV (18:18 NNHA)

TIME: Patient's identity verified by, patient stating name, patient stating birth date, hospital ID bracelet, IV established, 0.9NS 1 Liter hung, 2nd bag hung, Rate of infusion (non-bolus) Infusing at 125 ml/hr, via primary tubing, via gravity tubing, After procedure, no swelling noted at site, After procedure, no drainage noted at site, After procedure, no redness, Emotional support needed and given, Patient tolerated procedure well.

SAFETY: Side rails up, Cart in lowest position, Family at bedside.

[redacted]